Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1-DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name

UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative Box

Box Number: 46

MFDR Tracking Number

M4-12-1507-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letter. EOBs, claims, and documentation. The patient as referred for physical therapy. The service was provided and the bill was denied per EOB these are non-covered services because this is not deemed a medical necessity by the payer. CPT Code 97530 & 97110 were preauthorized, #1078202 therefore the service is deemed medically necessary. Per DWC Rule 133.301(a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the medical care provider has obtained preauthorization under Rule 134.600(h). In summary, it is our position that Risk Management has established an unfair and unreasonable time frame in payment for the services that were medically necessary and rendered to [injured worker]."

Amount in Dispute: $160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that this visit was not preauthorized, therefore, no reimbursement was due… The Carrier originally authorized 2 sessions for between 05/31-07/05/11… The Carrier authorized an extension for the 12 sessions for between 05/31-08/05/11… The date of service in dispute, 08/09/11, was not preauthorized, therefore, no reimbursement is due.

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2011	CPT Codes 94530 & 97110	$160.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The services in dispute were denied as not medically necessary by the respondent.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on January 6, 2012. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.
2. The requestor states in their position summary that the treatment was preauthorized; however, the respondent submitted documentation to support that the Carrier originally authorized 12 sessions of physical therapy from May 31 through July 5, 2011 and then authorized an extension for the 12 sessions from May 31, 2011 through August 5, 2011. In accordance with 134.600(l) the carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include: (1) the specific health care; (2) the approved number of health care treatments and specific period of time to complete the treatments.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 24, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.